Hyperbaric Oxygen Therapy Referral Form

Date: _____

Patient Name: _____DOB: _____SS #: _____

Address: _____

_____

Phone: (_____)_____-_____

This _____ year old male / female is being referred for Hyperbaric Oxygen Therapy ("HBOT"), as an adjunct treatment for the diagnosis listed below:

Diagnosis: (Check all that apply)

_____ Diabetic Ulcer of the Lower Extremity (Wagner Grade III, IV, or V)

_____ Chronic Refractory Osteomyelitis

_____ Preservation/Preparation of Compromised Skin Graft/Flap

_____ Late Radiation Injury (Radiation Cystitis, Osteoradionecrosis, Soft Tissue Radionecrosis)

_____ Arterial Insufficiency with Ulceration

_____ Other _____

Summary of Treatment Plan:
Initial treatment of 30 days of HBOT, as an adjunct to standard of care for above noted diagnosis, unless indicated otherwise. After 30 days, if evidence of healing has occurred, HBOT will be continued through complete healing. Continued HBOT will be coordinated with referring provider.

Referring Provider Information:

Referring Provider Name (printed) Referring Provider Signature Date/Time

NPI #

Street Address

City, State, Zip

Phone # Fax #

Primary Care Physician Name Phone #

Please fax completed form and supporting medical records to:

Hyperbaric Center at CCF Medina Hospital
Phone: 330-721-5127
Fax #: 330-721-5123